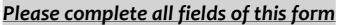
Patient Information Form & Privacy Statement

We are committed to providing our patients with the best care.

To do this it is essential that your health record is correct and kept up to date.





PERSONAL DET							Patient	File N	No #			
Title		Dr □	Mr □	Mrs □	Ms □	Miss 🛚	_ M	ast 🗆 🛛 O	ther			
First Name						N	1iddle	Name				
Surname						P	refer	red Name				
Date of Birth						Ge	nder:	Male 🗆	Fem	ale 🗆	Trans	gender 🗆
Ethnicity						Co	untry	of Birth:				
Do you identify a	s Aborigir	nal and/	or Torre	s Strait I	slander?	Abori	ginal	□ Torre	es Stra	ait Islan	der 🗆	No □
lf Aboriginal or Tori	res Strait Isl	lander, A	-		_	-		_	Yes 🗆	N	o 🗆	
			If not p	lease ask yoι	ır GP to provi	de you a f	orm to r	egister				
Languages Spo	ken Othe	r Than	English	1:								
OTHER DETAILS	5:											
Medicare No.						(IRN) F	Ref# a	on card		Expiry	<i>'</i>	
D.V.A No.	D.V.A No.					Gold]	White		Expiry	,	
Centrelink Pension/					P	ensio	1 🗆	Health Ca	re 🗆	Expiry	,	
Health Card No.												
Residential Ad	dress											
Suburb							Stat	:e		Postco	ode	
Postal Address							Stat	:e		Postco	ode	
Phone Numbers		Mobi	le:			Hor	ne:			Work:		
Any Known Al	lergies											
Email Address												
Occupation												
		Mr 🗆 Mrs 🗆 Ms 🗆										
		First Name: Last Name: Relationship with Next of Kin:										
Next of Kin Phone:				_		Rela	tions	nip with N	lext o	f Kin:		
Emergency Contact		Mr Mrs Ms Last Name:										
		FIRST	iame:			Pola		hip with E	mora	oncy Co	ntact	
Emergency Contact Phone Number:						neia	UOHSI	iip witii E	illerg	ency co	maci	•
PARENT OR GU	ARDIAN [DETAIL	S (Pleas	se compl	ete this s	section	if chi	ild is unde	r 16 ve	ears of a	ige)	
			_ (0 /	
First Name						Midd	lle Na	me				
Surname						Mob	ile Nu	mber				
Date of Birth						Relat	ionsh	nip to Chil	d			
Your Medicare	edicare					(IRN) F	Ref# o	on card	Ex	cpiry		
	<u> </u>											
LIFESTYLE HIST	ORY											
Alcohol	Drinker Non-Drinker How often do you drink per week:											
		How many drinks per week:										
Smoking	Smoker		⁄aper □		Smoker			of Cigare				
Exercise	•	Do you do any regular exercise: Yes No please specify type of exercise How Many Days Per Week? Hours Per Week?										
	Н	ow Mai	ny Days	Per We	ek?		Н	lours Per	Week	?		

	NT: Collection of Patients Information and Its Use Ilowing information, tick off each statement and sign below)									
As a patient of our medical practice, we require you to provide us with your personal details and other relevant information so that it can be registered in our system, assessed, and properly treated for your health needs.										
Your Medical Record is a Confidential Document. It is the policy of our Practice to always maintain security of personal and health information and to ensure that this information is only available to authorized members of staff. This information is collected in accordance with the National Privacy Principles and is used to manage your health care. If you wish to view a copy of our Privacy Policy, please ask one of our team members.										
We require your consent to collect personal information about you and to use the information you provide in the different ways: for example (a) For the use of administrative / operational purposes of our medical practice. (b) For Billing purposes, including compliance with Medicare and Health Insurance Commission requirements (c) Disclosure to others involved in your healthcare including treating doctors, other doctors, locum medical practitioners, registrars, trainees working within our group. Your information, also with other specialists and Allied health practitioners within or outside this medical practice. (d) To comply with any legislative or regulatory requirements e.g., notifiable diseases or for court summons. (e) For reminders (letters, SMS, and emails) which										
may be sent to you improvement prog	regarding your health and management. (f) to participate in research and quality rams.	,								
If you are not clear about any information or need further information – please talk to your doctors or Practice Manager.										
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.										
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.										
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.										
I consent to the handling of my information by the practice for the purpose set out above, subjected to any limitations on access or disclosure of which I notify in writing to the practice.										
I consent to being contacted by SMS/ phone call / letter related to my Health Issues (you will receive SMS recalls related to your health)										
I have read and understand the information provided above.										
PLEASE TICK ALL OF ABOVE ONCE READ										
Pl	ease present paperwork to reception with Medicare Card and Photo ID									
Signature	gnature Patient / Guardian Signature									
Patient ID No Patient ID required for under-age children, Guardian ID must be sighted by staff										
Guardian ID Guardian ID Must be Sighted for under-age children.										
Date										
This section to be cor	npleted by staff									
Checked By: Staff NameDateSignatureDate										